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EDITORIAL

LOOK at your watch. Follow the second hand round. From the sixty mark to the sixty mark, and then on another thirty-six seconds. In that pause of ninety-six seconds, somewhere in Britain someone has been injured in a road accident, because somebody was too busy, too selfish, too impatient, to pause to think and observe the highway code. By the end of the day that victim will have been joined by another 895.

How long do you take for lunch? An hour to an hour and a half? Whilst you are lunching, somewhere in Britain someone will die in a road accident. By the end of the day another seventeen victims will have joined him. Each day, every day, eighteen deaths, 896 injuries from road accidents.

To some of our readers these figures will not come as a shock. A district nurse is only too familiar with the call "Nurse, come quick, there's been an accident". She has too many opportunities of studying the effects of an accident, physical and mental, immediate and prolonged, on the victim and on his family.

But good can come out of evil. By speaking from her personal experience of the results of accidents, the district nurse should convince her listeners of the need for care on the roads. A few opportune words from her can save much unnecessary suffering and sorrow. For this preventive teaching to be really effective, she must herself adopt the highest standard of behaviour on the road.

Not nearly enough people are familiar with the rules of the highway code. Anyone taking to the road, whether on foot or on wheels, should realise that he or she has a personal responsibility to other road users. It is the human element which counts. To quote the foreword to *The Highway Code*: "Accidents on our roads do not just happen; they are *caused*—sometimes by a faulty vehicle, sometimes by road conditions, but nearly always by simple human error. These mistakes, which take lives, are made because in most cases we simply do not realise what we are doing until it is too late."

A five-month campaign to prevent injury and death on the road started last month with the theme: STOP ACCIDENTS–HONOUR YOUR CODE. If one section of the community gives a lead and supports this campaign wholeheartedly, others will follow. Most of our readers are public health nurses, who in order to prevent and cure illness are constantly using the roads. Your opportunity is clear. Will you take it?

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Two papers from the report of the 1959 Annual Conference of the National Association for Maternal and Child Welfare

The Effects of Maternal and Child Welfare Work on Problems of Population—I

by **J. W. B. DOUGLAS,** B.A., B.Sc., B.M., B.Ch.

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I SHOULD say at the outset that although for thirteen years I have been extremely interested in maternity and child welfare and have greatly benefited from the work of health visitors, medical officers of health and school nurses throughout the country, I have myself never been an active worker in the maternity and child welfare field.

My assignment is a difficult one because it is hard to assess the effects of an all-embracing service, such as the maternity and child welfare service, in retrospect. We know there has been a great fall in maternal mortality, in infant mortality and in mortality in childhood; we know that a great part of this fall must be due to the expansion and improvements in the child welfare field, but we are unable to say how much is due to these specific developments and how much to general improvements in living conditions. While it is undoubtedly true to say that the maternity and child welfare services have by reducing mortality offset the effects of falling fertility, it is impossible to say exactly how far and in what ways they have done this.

Although it is clear that the ideas spread by maternity and child welfare workers have altered people's views on desirable family size, it must be remembered that the maternity and child welfare services have always remained quite apart from the voluntary family planning services. Any effects on fertility which they may have had—and I believe that these were profound—have been indirect.

In the United Kingdom I see the problems of population as being of two types: first, problems of population pressure; second, problems of the quality of population. In talking of quality I am not considering it in the genetic sense but in the sense that certain sections of the population may be reproducing a different race from other sections of it and this may have an effect on the nation as a whole.

It is well known that during the nineteenth century the population of this country grew at a very rapid rate. In 1700 there were probably seven million persons in Great Britain. By 1801, at the time of the first census, there were about 10 million; by 1841 19 million and by 1881 30 million. Today there are nearly 50 million people in Great Britain.

The pattern of population growth in Great Britain differs from what one is likely to find today, or in the future, in economically backward countries. Fertility here started to fall in the 1870s at a time when mortality was high, when infant mortality was actually increasing, and when the maternity and child welfare services were in their infancy.

A recent study of the families of dukes showed a decline in family size starting about 1800, and from 1860 onwards there were large differences in the fertility of various sections of the population. The relatively prosperous and well-to-do began to have smaller families than the poor.

Smaller Families

By combining the figures derived from the 1911 census and from the recent family census of the Royal Commission on Population, we can state, in round terms, the extent of the fall in fertility since 1870. Among those married in 1870 the average family size was very nearly six children; among those married in 1890 the average family size was four children, and among those married in 1925 it was two children. In a period of just over fifty years there was, therefore, an extremely rapid decline in fertility.

One important fact to be learned from the experience of this country is that the population doubled itself between the time when fertility began to be controlled (in 1870) and the present day. This increase occurred in spite of the fact that there were other effective checks to population growth, namely, a high mortality, easy emigration and rapid industrialisation. This has to be borne in mind when considering the problems of the under-developed countries because they are in a much less favourable situation. Could Ceylon, for instance, or India, afford to double their numbers before reaching stability? Can they afford to see the control of fertility follow the same haphazard pattern as in Great Britain? In my view we cannot expect to see any sudden control of population growth in the under-developed countries unless some entirely new approach is made to the problem.

The reasons for the sudden fall in fertility in Great Britain, which started in the 1870s, are obscure, but two things about it are certain: first, the maternity and child welfare services played no direct part in changing

attitudes to family size at the end of the last century, because these services were then hardly in existence; second, although the decline in family size has been almost entirely due to voluntary limitation of conception, chemical or appliance methods of birth-control played only a minor part in this limitation. In other words, the methods which the Family Planning Association would today regard as desirable are not those by which the greater part of the decline in fertility in Great Britain was brought about.

Although the maternity and child welfare services have always dissociated themselves, to some extent, from the voluntary family planning movement, this does not mean they have had no effect on the desire of people to limit their families. By raising the status of motherhood, by emphasising the need for good maternal care and for a close and intimate relationship between mother and child the maternity and child welfare movement has also emphasised—though indirectly—the need for the planning of family size and the spacing of births. Moreover, by helping to bring about a fall in infant mortality—one of the greatest medical and environmental triumphs of the century—it has forced parents to limit the number of their children. What would have been a small family when mortality is high becomes a large one when mortality is low.

Bringing women together at maternity clinics has facilitated the interchange of ideas and may have led to more rapid adoption of the small family pattern. Other influences were, of course, at work—the women's papers, the desire for employment outside the home, etc.—but I am certain that without the sort of service we have had there would have been a much slower dissemination of ideas.

All this leads me to say that the maternity and child welfare movement cannot stand back and claim that it has not played an active part in the dissemination of ideas of family limitation. The accepted body of opinion on what constitutes good child care is built round the idea of a small family and, with few exceptions, a woman can only fulfil the exacting standards required of her if she limits her family. If people accept certain standards of birth spacing and family size they will achieve them; if not by medically efficient methods, then in less desirable ways.

Stillbirths Constant

In spite of the satisfactory and dramatic falls in infant mortality in recent years there has been a disappointing stability of stillbirths and deaths during the first week of life, which have shown little change for the last eight years. They represent a great challenge to the maternity and child welfare movement.

Stillbirths and first-week deaths are high among the poorest groups and are highest of all among young mothers who are having their first babies and among women who have had a rapid succession of births. They are also high among women who have failed to use the available ante natal services. High stillbirth and early infant death rates then are found among those women who have failed to plan their families and failed to use the services. These women also tend to have premature babies. It is important that we should be able to isolate these groups of women with high risks, and give them the help they need.

Problem of Abortion

Another even more serious problem is that of illegal abortions, which seems to me to come well within the field of maternity and child welfare. Owing to the legal position in this country, we know little about illegal abortions, but the Royal Commission on Population calculated that between two and five per cent of all conceptions ended in this manner. If this is true—and we would like more evidence—it poses a great problem for the maternal and child welfare movement. There are probably 30,000 illegal abortions per annum and the social and medical dangers are clear. The Royal Commission on Population report stated: "Abortion is a form of family limitation resorted to, for the most part, because of failure, through ignorance or other causes, to prevent conception. The use of relatively unreliable methods of contraception . . . is the cause of other distress that does not find expression in this extreme form; the harm arises not only from the failures, but also from the fear of failure." Thus again we are faced with need for the maternity and child welfare services to define their attitude to family planning.

In Scandinavia the legal view on abortion is different from that in Great Britain. We may not agree with the Scandinavian attitude, but we can learn from the experience gained. One of the most striking findings was that a considerable proportion of women seeking abortion through legal channels were, in fact, married, and that nearly 40 per cent of them were not pregnant at all. The latter observation suggests that there is much to be said for setting up a confidential pregnancy diagnosis service, since there is no doubt that if these women had gone to an illegal abortionist the fact that they were not pregnant would not have altered the action taken.

It appears that in Scandinavia there is a group of women who are worn out and physically sick, who are a resistant group in the attempt that society is making to reduce the frequency of abortion. The majority of these are elderly women who have become pregnant without intention and who cannot bear the thought of another child because of the work and trouble involved; these women would rather risk their lives and health than carry their pregnancies to term. If the same is true in Great Britain—and here we need more evidence—it is a problem from which the maternity and child welfare services cannot turn away.

It has been suggested that now that infant and child mortality is so low, the maternity and child welfare movement has come to the end of the road; that the time has come to disband its workers and turn over the conduct of infant health and child health to the hospital

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The Effects of Maternal and Child Welfare Work on Problems of Population—II

by **B. S. PLATT,** C.M.G. M.Sc. Ph.D. M.B. Ch.B.

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LET me begin with a little bibliography. There are many books written on the problems of population. For those who wish to study the problem seriously I suggest *World Population and Resources*, a report by P.E.P. (Political and Economic Planning). If you like your pill sugared there is a new publication by Colin Bertram *Adam's Brood* whose ability to write a book so fascinating and entertaining on such a serious problem I envy. Those concerned with infant nutrition in overseas countries might like to know about the World Health Organisation publication *Infant Nutrition in the Sub-Tropics and Tropics*, by D. B. Jelliffe. There is also a paper I published in *The Lancet* on November 6th, 1954, entitled The Mal-Nourished Community: Care of Mothers and Children as a first step towards Improved Feeding. In that paper I built up a case somewhat different from that which Dr. Douglas has described, for using at the outset the maternity and child welfare services not only for death control but for birth control, the clinics of these services seemed to me to be the logical points at which to start both types of control.

Needs and Supplies

You may wonder why I, as a nutritionist, have anything to do with the population problem. I am not a demographer; I have, however, worked with mothers and babies, both human and experimental animals, for most of my professional life. There came a stage a few years ago when it became very plain to me that we had to look at both sides of the equation which relates food needs to food supplies; this is a basic equation which should be satisfied not only on an individual basis but for communities and indeed for the whole world. If we fail to meet our needs, both quantitatively and qualitatively, we become malnourished; in certain communities if we do more than meet them we become overfed, which is almost as serious a problem of malnutrition in many ways as being underfed. There is obviously a limit to the area of land which can be cultivated and to the size of crops that can be raised from a given area of land. One day, probably fairly soon, the equation so far as the world is concerned, supplies and needs, will have to be balanced; otherwise there will be more of the usual causes for wars.

I have been asked to look at the problem from the point of view of developing overseas countries. It was clear from Dr. Douglas's paper that we have been through various stages of population growth in this country. There is a fairly regular pattern for the growth of populations known as the "population cycle" which can be illustrated from information available for England and Wales over the past 200 years. This "population cycle" consists of four stages. Stage I covers a period of high birth and high death rates. Stage II in England and Wales was from 1750 to 1880, when there was a growth of the population of 300 per cent. During this period the birth rate remained more or less high and the death rate declined; in Stage III, both birth and death rates declined during a period of fifty years, from 1880 to 1930, when the population increased again by 50 per cent. Stage IV is a more or less stable stage with birth and death rates low. One can classify countries according to the stage of population growth which they are in. The only part of the world still in Stage I is what I call "Middle Africa", i.e. Africa south of the Sahara, but excluding the Union of South Africa.

During the 200 years 1750–1950 there have been what are called four "revolutions" in England and Wales: revolutions in medicine and hygiene, in agriculture, in which there was increased crop production, new techniques were introduced including the mechanisation of agriculture, improved methods of storage and the like. An industrial revolution helped to provide the machinery for mechanising agriculture, provided transport for people to get about the world and to bring food from other parts of the world to this country, and so on. Fourthly, a revolution in the control of births.

The Wasted Half

The value of this analysis is that we should be able to understand some of the factors in the growth of population and we should be able to help our fellow men in other parts of the world to try to avoid the undesirable effects of increasing population. You have been reminded of Dr. Johnson's letter to his friend Boswell, when he said he was lucky to have three out of four children alive. In many parts of Africa mothers are lucky if half the babies born survive the first year of life: i.e. there is an

infant mortality rate of 50 per cent or 500 per 1,000. And that is not fiction. I have actually encountered infant mortality rates of this magnitude in villages in Africa. Very few people realise how big a wastage of life this really is. These high mortality rates are partly due to malnutrition, partly due to disease such as malaria. Although I am a nutritionist by trade I would support the malariologist before the nutritionist in this if I had to choose one of the two, because it is much cheaper and quicker and much more effective to get rid of malaria than to get rid of malnutrition. It costs at least one-eighth or one-tenth as much to eradicate malaria as to counter malnutrition. The figure for Nigeria has been said to be about 5*s* per head of the population per annum for a malaria eradication programme. Often, however, the effects of malnutrition and malaria are indistinguishable. In tropical countries where diseases such as malaria and hookworm are endemic, there is difficulty in sorting out what is due to zymotic disease and what is due to malnutrition. Indeed, I do not think we can really know the full story until we get rid of the endemic disease.

Economic Value

When the infant mortality rate is not as high as 50 per cent it will be found that nearly half, or more than half, of the children born die before they reach the age of ten or twelve years, so that it is not merely a question of infant mortality. The effect on the parents is interesting. When talking to some of the older people in an African village about these questions they will say they have four children in order that two or even one may survive to take care of the parents in their old age. That is, in Stage I, children are an economic asset. It seems in the later Stages the child becomes an economic liability. If you want to tackle this problem you have to recognise that this is the philosophy, if there is a philosophy, behind having a number of children. If you have death control in operation and you are going to tackle the next problem of birth control, then one of the major problems to be dealt with is the attitude to children as economic assets as compared with economic liabilities.

The next piece of advice I would like to give is in the form of an aphorism, and that is: "Temper innovation with the restraint of legitimate custom". All who get a "do good" complex think things have necessarily to be changed. After a lengthy experience I strongly advise no one to rush in without first ascertaining what existing customs are. I do not think anyone could go into any village in any part of the world, however poor, and not find some of the people there relatively better off than others. Even though things are poor all round, somebody is, with the tools at hand, doing better than someone else. It is necessary to find out why those people are better off and try to bring others up to the same level, and then proceed from there. By the time this has been found out, one will probably find many things that can be used as a basis for improvement—for innovations.

One of the enthusiasms those going from Great Britain to overseas countries to do maternal and child welfare work take with them is the artificial feeding of the human infant; one of the innovations which almost everywhere is quite different from indigenous practices is the weaning of infants from the breast at three, six or nine months at most. Babies in unsophisticated communities generally take some breast milk up to the age of two and three years, and in some communities even longer, perhaps up to ten and twelve years of age. We have good evidence to show that it was not long ago that some babies in this country took breast milk up to the age of three and four years.

Coupled with breast feeding up to two or three years of age there is another attitude towards having children which is common right across Africa, a very big continent. I have seen both in East and West Africa the attitude towards the spacing of birth of children. In polygamous communities a wife becomes pregnant, has a baby, and goes out of circulation for two of three years. If she has a baby within that two or three years that baby is given a name which attaches a stigma to the parents for having broken the tradition that the mother should not have a second baby before the first has had its birthright of breast milk. It did not take paediatricians or demographers to do that. Kwashiorkor, which is one form of protein malnutrition, really means that a baby with the disease has been deprived. It is well recognised that a child has been deprived of its birthright; in other words, there has not been proper spacing of the family during reproduction.

Our Responsibility–Leadership

Finally, what is our responsibility in this matter? Colin Bertram puts it well, and I could do worse than read what he has to say:

> "You and I, we benign yet lazy literate Christians with so many of the material good things at our disposal, we must not assume that all are as ourselves, for they are not: Facts must be faced, by our children if not by ourselves, and those facts include genetic and biological reality. That which is desirable will not appear by chance and inactivity: we must rely on deliberate wise action based upon an informed public opinion, influenced by leaders of surpassing vision—and that they most certainly will not have without sound training in the real facts of life. . . . Can one hope that Britain has a special part to play in leadership in this as in so much before, from the improvement of our domestic creatures to pioneering in contraception itself? That leadership needs, pre-eminently, people of goodwill, tolerance, appreciation of difference both between individuals and between their aspirations, and a broad biological education, together with realisation of the true and not the spurious relationship between contentment and material affluence. Yet even if Britain could prove herself a paragon, she would exert little effective leadership until once more there is developed a broadly accepted objective in life itself".

By listening with care to what our patients tell us, we shall begin to understand not a symptom or a diagnosis or a mental disorder, but a whole human being in distress

Early Signs and Symptoms of Mental Disorders

by **BERNARD MALLETT,** M.B., B.S., M.R.C.S., M.R.C.P., D.P.M.

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DURING the last decade there has been an increasing tendency to treat patients suffering from mental illness in their own environment. Although every case is by no means suitable, there are very real advantages to be obtained with this system whereby the patient is treated either at home, or at a day hospital or clinic, without fear of isolation and desocialisation in a mental hospital. One particular advantage is that by means of domiciliary visits, psychiatric illness may be dealt with at an early stage when it is likely to respond more readily to treatment. In an integrated mental health service the district nurse, working in the home, is in a particularly favourable position to observe and recognise psychiatric disorder before serious symptoms have developed or serious breakdown has occurred.

It is important, therefore, to be aware that mental illness may begin insidiously and pass for months or even years unrecognised as such, with much resultant suffering for both the patient and his relatives. Thus, behaviour may be disturbed, and a man or woman may perhaps become self-centred, hypochondriacal, querulous, suspicious, untrustworthy, idle or cruel, not culpably or through perversity but because of incipient mental disorder. If we are aware of this and can find the time to let our patients tell us of their troubles and fears, we shall sometimes recognise in their talk and actions the signs and symptoms of early mental disorder. In this respect it will be helpful to know something of the nature of the disorders which commonly occur and which we may encounter in the home.

Mental illnesses may be divided into two main groups, the organic and the functional. Organic mental disorders include all those which are undoubtedly due to some underlying bodily disorder; for example, general paralysis of the insane is due to syphilitic infection of the brain. The functional mental disorders on the other hand have, as far as we know, no certain organic structural basis.

On consideration of the organic group it is at once apparent that the early signs and symptoms may not be insidious, subtle and difficult to recognise, but sudden, large and conspicuous of madness. Thus, in cases where the structural change has been sudden and acute, as in fevers, intoxications, gunshot wounds of the brain and so on, there will be a mixture of delirium and dementia which will alarm the relatives and will certainly not be overlooked. Fortunately, this severe disturbance is often seen in cases where the underlying damage is completely reversible. It is not necessary to describe, for example, the phenomena of acute alcoholic intoxication.

More slowly progressive changes are seen in association with slowly developing cerebral damage or disease. In our geriatric patients we may observe the slow loss of intellectual function that is typical of the senile, presenile and arteriosclerotic dementias. There is an inattention, a distractability and a failure of recent memory, often linked with emotional shallowness and lability. The patient's forgetfulness may lead him to lose his way or mislay small articles, so that he becomes crotchety and suspicious. At night he may wander restlessly from room to room, muttering, confusing fact and fantasy, stumbling, falling, perhaps even setting fire to himself or the house.

Occasionally, the early signs are tragically missed until the patient breaks the law, bringing social disgrace upon himself and the family. Petty pilfering may occur, or in elderly men who hitherto have led most decent lives, a recrudescence of sexual desire with failing powers and loss of control may lead to indecent exposure or offences with little boys.

Apart from actual damage to the brain, mental dysfunction may occur in association with glandular disturbances. Paracelsus, as long ago as 1526, noted the association between foolishness and goitre which was later described by Sir William Gull (1873) as a "Cretinoid State supervening in Adult Life in women". This is the condition we now call myxoedema and it is well to bear in mind that disinclination to mental and muscular activity may not be attributable to inertness of the will or culpable laziness but to deficiency of the thyroid hormone, and may be cured by small doses of thyroid gland. Hoarseness of the voice may give a clue to the diagnosis. Sometimes of course, the thyroid gland produces too much hormone; then the patient may become anxious, irritable, restless and unhappy, shouting at the children, nagging her husband, crying and flying into tempers. This, too, is a condition amenable to treatment.

Let us consider briefly the second main group of mental disorders, those we called functional. There are some in which the disturbance is primarily emotional.

These are the affective disorders of which the two most common are states of anxiety and states of depression.

The anxiety state is characterised by persistent feelings of troubled uncertainty, anxiety and tension, apparently without cause. The patient is worried about everything but is not at all sure why he is so worried; he feels an unknown, inescapable catastrophe is about to come upon him. The quality of the anxiety is exactly like that experienced by healthy individuals in the face of appropriate stress and it is accompanied by the bodily changes we all know—the rapid pulse, dryness and often a nasty taste in the mouth, anorexia, sometimes trembling and sweating, difficulty in getting to sleep, and restless sleep disturbed by nightmares.

Sometimes the bodily symptoms predominate and then it may not be recognised that the patient is suffering from a mental illness; the condition may be put down to "nervous overwork" or "disorderly action of the heart". Much unnecessary invalidism has been caused in this way. Anxiety states are probably the commonest type of emotional illness. Moreover, we should always remember that there is no illness that is not accompanied by some degree of anxiety for the patient and for the relatives. People are frightened when they are ill. Though many a time this anxiety is not overtly expressed, we should always be aware of it and relieve it where we can.

Not Just Moody

Depression, like anxiety, is a normal emotional reaction which we have all experienced following the unalterable loss of some accustomed or expected source of gratification. Apart from this, many of us experience swings of mood; we have our "ups and downs" without reference to environmental happenings. In our "ups" we may feel confident, gay and well, but in our "downs" we are depressed both in our spirits and our physical well being. Sometimes depression, whether it follows an understandable cause for grief or whether it is merely a phase in our natural mood swings, may persist, not lifting but gathering its own way. It must then be regarded as a form of mental illness particularly characterised by sadness, despair, or sometimes a dullness of feeling, with slowing of thoughts and bodily processes and loss of interest in living.

In severe cases this is not difficult to recognise. But in chronic mild or early cases it may be construed almost as perverseness and the patient exhorted to "pull himself together" or to "take an interest in something". These are, unfortunately, just the things which because of his illness, the patient is unable to do. Thus we see how important it is to recognise this as a mental disorder, in which early treatment may save the patient and his family months or years of miserable distress.

There is a particular type of depressive illness which occurs quite frequently during or after the involutional period of life in women and in men, called involutional melancholia. There is often agitated restlessness with the depression, and hypochondriacal fears or delusions of bodily illness; for example, the patient thinks that the bowels are unduly sluggish, or blocked or rotting away inside or that the brain is failing or going bad. Such complaints of bodily ill health may be the earliest signs of an underlying depressive illness which may go unrecognised for many months.

The other and far less common side of the penny is elation, mania, or hypomania as it is known in its milder forms. In such an illness thought is quickened and the spirits high. The afflicted person is excitable and full of energy but distractible, rushing from one task to another and never completing anything. He may mismanage his affairs through unwise and rash decisions, spend all his savings foolishly and expansively, and neglect his personal health by not allowing time for adequate meals or rest, before the condition is finally diagnosed.

The second great class of functional mental disorders approaches more closely the old idea of true madness. These are the schizophrenias. In the later stages they are easily recognisable but at their onset they are often insidious and may for a long while be mistaken for foolishness, eccentricity or moral perversity.

Schizophrenia may appear, rarely, in childhood, but much more commonly in late adolescence and early adult life and again in the fourth and fifth decades. In this devastating and common illness there is a splitting of the personality, a disintegration of the normal harmonious unity between thought and feeling and action. The significance of events and things is in some way changed for the schizophrenic patient. He lives in a different world from our own, as C. G. Jung has described it, "like a dreamer awake".

There are three main forms of schizophrenia. The first includes the hebephrenic and simple types. These begin in the late 'teens or early twenties and run a chronic course, sometimes with remissions or recovery but only too often resulting in a steady deterioration. Early in the illness these may be a blunting or flattening of feeling and an impairment of the will. This may lead to lack of consideration for closest relatives and friends, or gross neglect of children or elderly parents, a neglect in fact of social obligations, indifference, callousness, inability to make decisions and a slow drifting down the social scale into unemployment, poverty and petty crime.

Disrupting Family Life

If the will is less blunted, and drive less impaired, the shallowness of affect may result in the patient leading an actively anti-social existence, or sudden brutal crimes may be committed by an apparently harmless, solitary person. The effect of simple schizophrenia, unrecognised, on marriage and family life may also be devastating and disruptive. Patients themselves often have no appreciation of their shortcomings, no awareness of the progressive change in their personality, but may complain only of vague hypochondriacal symptoms and fears.

The second form of schizophrenia, catatonic schizophrenia, we need mention only briefly, for the onset, usually between the ages of 20 and 35 is often acute,

sudden and catastrophic. The illness may begin with sudden stupor, muscular rigidity, or strange posturing which may be explained as meaningful, for example, stretching of the arms symbolising Christ and crucifixion; or a sudden outburst of wild excitement may occur without previous warning. Thus the early symptoms of this grave illness cannot fail to attract attention.

The third form of schizophrenia however, may develop gradually and unnoticed. It occurs in the middle aged and elderly and is called paranoid schizophrenia. Paranoid means having a resentful sense of a hostile environment, and the illness is characterised by delusions of persecution. It is true that paranoid mechanisms exist in all of us and can be activated in most of us to some degree. Your friends may have stopped talking as you approached and you perhaps jumped to the conclusion that they were talking about you in a derogatory fashion; or you may have sat alone in a restaurant and felt that the other diners were regarding you somewhat critically.

Indeed it is a mark of our essential normal humanity that we tend to project our guilty feelings and our doubts about our personal worth on to other people and so come to believe that they are criticising us for being weak or worthless or unpleasant. This is a normal mental mechanism, but in some it becomes an habitual response and we may say that such people have a paranoid personality; in a few, such paranoid projections may carry delusional conviction and may then be the early signs of schizophrenia.

I would make special mention here of the puerperal psychoses. After childbirth, a woman may become ill with the signs and symptoms of depression or schizophrenia, or both together. The earliest sign may be a disinclination to care for her baby. This is a very distressing illness and may be dangerous for the child. Puerperal psychosis usually responds well to early treatment and we must bear in mind that a new mother may not be lazy, selfish or weak-willed, but mentally ill.

Recognition Not Enough

In the last great class of functional mental disorders we may include the obsessions and compulsions, hysteria, and the great hotchpotch of character disorders that are called psychopathic personality. Of these, we should perhaps be particularly concerned with hysteria, not because the early signs of this illness are commonly missed, but because they are commonly recognised and it is sometimes felt that this is enough.

Hysterical symptoms have been defined by Sir Charles Symonds as "symptoms, which are not of organic origin, but are produced and maintained by motives, never fully conscious, directed towards some real or imagined gain". Again, Sir Aubrey Lewis writes in Dr. F. W. Price's *Textbook of the Practice of Medicine*, "Hysterical illnesses represent the attempt, never fully conscious and frequently completely unconscious, on the part of the patient, to obtain some relief or advantage from the exhibition and experience of symptoms of illness".

You will notice how both these definitions contain the phrase "never fully conscious" and it is this we must always bear in mind when we are dealing with an hysterical patient. The patient is not malingering, for malingering is the conscious simulation of disease. He is unaware of the way in which his symptoms are produced. To the patient they are real symptoms. The advantage gained may be largely illusory and the symptoms both painful and crippling, but they may at least gain for the patient attention, sympathy and interest; they may provide a partial expiation of feeling of guilt, and they may symbolise the mental conflict which underlies their production.

The symptoms themselves may take any form of disturbance in the skeletal musculature or the sensory systems, so that you may see every sort of paralysis, palsy or numbness, sudden blindness, loss of voice, seizure or attack. These symptoms may be very difficult to distinguish from those of organic bodily disease, but often they are not. Often they are transparent and clear to all but the sufferer and we may be tempted therefore to reject them out of hand.

Distress Signal

But always we must remember that *hysteria is a danger signal.* It is a flag held up to say, "I need help". It is a buoy floating above a wreck. There is always a cause. Underlying this condition there may be one of three things; firstly, psychological stress or conflict which the patient cannot resolve unaided; secondly, the patient may have some structural disease in its early stages so that he or she is aware, as human beings sometimes are, of the onset of grave illness before there are any physical signs. Lastly, hysterical symptoms may occur in the early stages of a mental illness, such as depression or schizophrenia, when the patient is aware that something is going wrong, something which he is unable to define but which is of an overwhelmingly threatening nature.

So we see that hysterical symptoms may be transparent and obvious, crude yet crippling; they may provoke resentment and scorn in the onlooker, yet always they signify that a human being is threatened by something with which he cannot contend alone. They are a cry for help and it is our task to recognise them for what they are and to answer that cry to the best of our ability.

And this, of course, is true of all that we have discussed. The presentation of symptoms is always a plea for attention. We must meet it with objective concern and with detached compassion, aware of the possibility that the symptoms presented to us may sometimes be indicative not of bodily disease but of mental ill-health, and in the knowledge that by listening with care to what our patients tell us we shall begin to understand not a symptom or a diagnosis or a mental disorder, but a whole human being in distress. By attending we shall begin to understand; by understanding we shall begin to be able to help.

Thrumpton Hall

Photograph by courtesy of Country Life

Peaceful Retreats

"I WANT to tell some of my patients about the gardens they could go and see," remarked a district nurse recently, as she bought a copy of this year's guide to gardens to be opened for The National Gardens Scheme. The current interest in gardens and everything connected with gardens surely plays no small part in counteracting the pressures of life today, and there must be many people who could be stimulated to take an interest in growing things, even if only in window boxes, by going to see other people's gardens. There is much, too, to be said for the peace and relaxation to be gained from visiting gardens, even for people who have no opportunity of growing things themselves.

One of the most peaceful spots in the country is the village of Thrumpton in Nottinghamshire. The gardens surrounding the Jacobean mansion at Thrumpton Hall are to be opened on 3rd July.

The grounds are varied in layout; to the north of the Hall is the ornamental lake pictured above, and on the south side there is a formal garden in keeping with the Jacobean origin of the house; there is, too, a secret garden enclosed in high clipped yews, and there are informal gardens merging into the park. One of the features of the grounds at Thrumpton Hall is the fine trees, including one of the oldest larches in England.

But gardens do not depend upon rural surroundings to provide a peaceful retreat. A feeling of peace and quiet can be found even in gardens in the middle of big cities. Such a one is the garden at Park House in Onslow Square which will be open this month on 23rd June. Here in a space the size of two tennis courts can be found a wonderful variety of plants, trees and layout, and a feeling of seclusion altogether surprising when one remembers that the garden is scarcely a mile from Victoria Station.

The question no longer is whether it will be conquered but when it will be conquered

The Answer to Cancer—When?

by **DR PIERRE RENTCHNIK,**

University Medical Clinic, Geneva

AMONG the great scourges that periodically decimated the human race there are few that have not been forced to yield to the attack of medical science. Leprosy, syphilis, tuberculosis, malaria and most other infectious diseases are all becoming less common; some of them will possibly disappear.

However, cancer continues to be a major preoccupation of medical science and the world in general, for this disease raises a number of problems that are difficult to solve as long as the causative agent is unknown. In the absence of specific treatment, that is to say treatment which directly attacks the cause in the same way that an antibiotic blocks the growth and spread of the causative organism of an infectious disease, the cancer campaign must be vigorously waged on several fronts: by statistical and epidemiological investigations, by propagating the idea of early detection, and by keeping the public fully informed of the current situation.

Has cancer increased in frequency? Some forms are certainly commoner, partly because medical science has learned to diagnose them, and also because the mean expectation of life has been extended by advances in public health and clinical medicine.

As we know, the cells of the human body, under the influence of a regulating mechanism probably sited in the stem of the brain, are born, live, and die at a rate that varies according to the kind of tissue involved, the organ, certain exceptional circumstances such as accidents, burns, etc., and finally, the age of the individual. When, as a result of deterioration of this regulating mechanism, the cell division rhythm is upset because of mechanical, physical, chemical or other reasons in association with a factor X (which some people think is a virus), cell division may occur more rapidly and daughter cells arise which begin to form a tumour and live like parasites at the expense of healthy neighbouring cells. Some tumours will remain benign, in other words are strictly localised at the site where they arise, while others may become malignant by erupting into the blood stream, which carries the cancer cells to different organs, mainly the lungs and bones. This spread of cancer cells takes place according to laws as yet not elucidated.

What is the point of spreading knowledge about cancer more widely than in the past? The purpose is to attract the public's attention to the fact that early diagnosis enables many lives to be saved. Nowadays, with a larger number of methods at our disposal, early diagnosis of a malignant tumour is possible if the patient is examined in time. This early diagnosis is of supreme importance, because the time between the beginning of the tumour's growth and the dissemination of daughter cells (metastases) in the blood stream is, in most cases, relatively long, extending over several months or years.

During this period minor signs and symptoms may be of the greatest importance and should oblige the patient to go to a doctor. They include injuries which show no tendency to heal, lumps and slight thickenings in the breast, unaccustomed loss of blood from any of the orifices, constant digestive upsets or difficulties in swallowing, alternate bouts of constipation and diarrhoea with slight traces of blood in the stool, persistent cough or hoarseness, prostatic enlargement and repeated attacks of bronchitis.

The doctor, by a blood test, examination of the stool or X-rays, can study and watch the development of any one of these symptoms, perhaps detect a cancer at its very beginning, and, depending on the site, propose that it be treated by X-rays, cobalt bomb or surgery. These assertions, far from being imaginative, are solidly backed by statistics. The campaigns for early detection in the United States, the compulsory check-ups in the U.S.S.R., the organised examinations in certain other countries have saved many patients' lives through early diagnosis.

Women particularly should undergo regular medical checkups from the age of 30 or 35 on, so that any incipient malignant tumour of the breast or uterus can be detected and treated in good time. In the U.S.S.R., where the patient not only has the right but also the duty to be in good health, we were able to see, in the course of two visits in 1954 and 1956, that the advanced stages of cancer of the uterus were unknown, for examination was compulsory, well organised, and accepted by the women who were regarded not so much as members of the population but as active and productive elements of a factory, an administration, or an institute.

The following statistics, published in the United States, show how the chances of cure depend on the early establishment of a diagnosis:

	Rate of cures where the diagnosis early: %	*late:* %
Cancer of the breast	78	36
uterus	70	35
lips	90	15
skin	95	40
rectum	40	3
bladder ..	55	5
large intestine ..	85	14

People familiar with such statistics, published and commented upon by official medical institutions, are less frightened by the thought of cancer and are conscious of the need to undergo periodic check-ups in special centres.

By laying the bogy of cancer through educating the public, the campaign for early detection and treatment can be more successful. It will never be known how many thousands of deaths have been caused by false modesty, shyness, the fallacies of popular medicine, or even fear, in people who went to the doctor too late.

Medical associations have perhaps their share of responsibility here. They should play a more active part in the cancer campaign through the press, radio, and television. A campaign conducted on a national scale should obviously be well organised so that the public will not be frightened by words or descriptions which overstep the bounds of reality and unnecessarily create a "cancerophobia". Health education should therefore be continuous so that little by little scientific and technical terms become familiar and do not create panic. At the present time education tends to be too piecemeal, and cancer is usually mentioned in connection with the death of a politician or a film star. Then there is a wealth of more or less imaginary detail, and the general view is confirmed that the diagnosis of cancer is equivalent to a death sentence.

Should patients be Told

Should the patient in whom the doctor has found the beginnings of cancer be told about it? By tradition the doctor tends not to tell his patient when he has a disease of very doubtful prognosis: he holds the view that the patient, already perhaps weakened by the disease, runs the risk of not being able to face the disclosure of the exact nature of his illness. We are not convinced that this is wise—and our view in this matter coincides with that of advanced American medicine. The classical position typifies a certain passive attitude towards the fight against the scourges of society. The new generation of doctors tends to admit the right of the patient to know the truth, but feels that he must be told in a suitable way. The patient must be made to understand that he is dealing with someone who wants to put up a fight, not with a judge who is sentencing him to treatment or to an operation as punishment. This is the view of Professor Jean Bernard, who writes: "The most valuable, indeed the only, help is that given by those who try to understand, share, and bear the burden of their patient's sufferings. The truth should sometimes be kept secret for a long time, sometimes disclosed at once, and sometimes—perhaps without anything being said in so many words—slowly communicated in the course of conversations".

In the United States, the word cancer does not have the same overtones as it has in Europe. We had an opportunity to visit the Anderson Hospital in Houston, Texas, which bears the name Cancer Hospital on the front. There we found a relaxed atmosphere and patients who had confidence in the doctors, who discussed frankly the possibilities of cure. In Great Britain, doctors in Manchester have for the past two years been studying the reactions of cancer patients, who had been told the nature of their illness: of the patients interrogated, only 7 per cent (and these, astonishingly, women) disapproved of patients being told the whole truth. In this enquiry it was shown that many patients were afraid of the term cancer because they did not realise that early detection would make cure possible. This British investigation is interesting because it shows that the public is ready to

Miss Dixon Off To Spain

Miss Nancy M. Dixon, Deputy General Superintendent of the Queen's Institute, boarding a plane at London Airport.

At the invitation of the British Council, Miss Dixon is visiting Spain and Portugal where there is no properly organised health visiting or district nursing service. The provision of this service is being considered in connection with the complete reform of the training system for nurses.

The tour includes a series of round table discussions and lectures in each country, and in order to give a clear picture of the public health services in this country Miss Dixon will meet members of the health service and will visit hospitals and clinics in various parts of the country. She will see at first hand the conditions and problems existing and will advise accordingly.

This is the second overseas tour undertaken by Miss Dixon. In 1956 she visited Canada and Jamaica and advised on the setting up of the first district nursing service in Jamaica: the Hyacinth Lightbourne V.N.S., which is now a rapidly expanding organisation staffed by Jamaican Queen's nurses.

co-operate with the medical profession as long as the aims and possibilities of energetic action against cancer are explained by an information programme directed and organised by the medical profession itself. At the conclusion of their enquiry the Manchester doctors decided that there were greater reserves of courage and resolution in the human mind than they had realised.

By making an effort to educate the public and patients about cancer, we can little by little eliminate some of the taboos attached to certain terms, such as happened in the past with syphilis and tuberculosis, and thus bring about better co-operation between patient and doctor with a view to early diagnosis and treatment. Yet the truth should only be told to those who are capable of facing it, either because their faith or philosophy of life enables them to do so, or because their knowledge of medical progress puts them on a par, for example, with the American patient.

Treatment Available Today

At the First International Symposium on Anti-Infectious and Antimitotic Chemotherapy, held in Geneva last September, Professors A. D. Karnofsky (New York), W. Dameshek (Boston), J. Bernard (Paris) and L. Laronov (Moscow) described the treatment now available for different forms of cancer. By means of surgery, X-rays, the cobalt bomb, and various chemical substances, considerable, sometimes definitive, results can be obtained in a whole range of cancers diagnosed early, even sometimes at a late stage. In the last ten years or so numerous cancer-destroying methods have been tried, but doctors have often been held up by the excessively toxic effects of the substances used or by the danger of X-rays. Two new possibilities in the cancer campaign present themselves. The first consists of greater selectiveness through remote control, the idea being to achieve carriage of anticancerous substances directly to the malignant cells alone, without harming healthy cells, using a carrier that might be an antibody, hormone or antibiotic. The bone marrow grafting done on the Yugoslav scientists is another pointer to progress. As is known, radiotherapy is of limited use in certain forms of cancer because of the danger of destroying the bone marrow centres by excessive doses of X-rays. British workers removed the marrow before radiotherapy, froze it and replaced it after treatment with X-rays. The results obtained give rise to the hope that in this way X-ray treatment can be pressed further.

These trials, and the results obtained so far, have altered the defeatist attitude that was still characteristic of the doctor as recently as ten years ago. We must think beyond the patient of today to the patient of tomorrow. The encouraging results hitherto achieved fully justify the world-wide enthusiasm for the cancer campaign. As has been said by late Dr. Cornelius P. Rhoads, Director of the Sloan-Kettering Institute, New York, the question is no longer whether cancer will be conquered, but when it will be conquered.

TAILORED FOR TIMOTHY

THE manufacturer of a complete range of foods for babies, from birth until they are ready for adult meals, Trufood Ltd., has sponsored a film on the basic principles of feeding young children. *Tailored for Timothy* is designed particularly for use where an expert is available to answer questions, such as at mothercraft classes and ante-natal clinics.

Shot in full colour, the film describes the feeding of two boys, Nicholas and Timothy. Both are normal, healthy first babies of the same age but they start life with one basic difference—Nicholas is breast fed but Timothy's mother cannot feed him herself. From weaning, however, both follow the same pattern and this is thoroughly but simply explained.

The commentary is written as though spoken by the district nurse who also acts as health visitor, taking over the care of Nicholas and Timothy when they return home with their mothers from the hospital. At the end of the film she explains that she has had to give up her work. The final shot shows why: she is seen in bed with her twins.

Tailored for Timothy was made by Eothen Films with the co-operation of the Royal College of Midwives and of St. Thomas' Hospital. It is a 16 mm. film (with optical sound) in Technicolor and it runs for thirty minutes. It is available free of charge for showing to mothercraft classes, and is distributed for the sponsors by G. B. Film Library, Aintree Road, Perivale, Greenford, Middlesex. Copies may be ordered either from Trufood's London office at 113 Newington Causeway, London, S.E.1., or through the company's representatives.

Earlier this year the same firm introduced a new detergent steriliser which provides a "simple, efficient and economical method of cleaning and sterilising in one operation," designed primarily for infants' feeding bottles, teats and other feeding equipment.

Nursery Hysan is in the form of a white powder and is packed in glass bottles with plastic screw caps. Full directions for its use are printed on the label. Price 2*s*. 6*d*.

The Effects of Maternal and Child Welfare Work

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services. This suggestion reflects a point of view which is only understandable if we judge the effects of the maternity and child welfare services by mortality alone, and there could be no greater mistake than to do this.

I have tried to show that social factors in maternity and child welfare are more important today than they have ever been. Public health depends more and more on modifying the behaviour of relatively small groups of individuals in the community rather than on changing the environment and education of the masses. The question is whether a service that was designed to meet the needs of the 1920s can adapt itself to meet the equally urgent needs of today.

Queen's Institute at Torquay Exhibition

Some 3,300 delegates attended the 1960 Congress of the Royal Society of Health, held at Torquay during the last week in April. The sections, conferences and demonstrations, and the exhibition held in conjunction with the Congress, covered the whole field of public health: in dealing with current problems and in looking ahead to the future the speakers and those taking part in discussion emphasized the need for co-operation.

The President of the Conference of Domiciliary Nurses and Midwives, Mrs. Derek Walker-Smith, laid stress on the need for a more complete co-ordination between hospital, general practitioner and the domiciliary services. In speaking to her paper on "The Challenge at Home: the district nursing service", Miss Joan Gray, General Superintendent of the Queen's Institute of District Nursing, spoke of the need for a wider view of the nursing profession as a whole, and for each member of the public health team to have as thorough a knowledge as possible of her colleague's work, and of the contribution which the new Integrated Course of Nurse Education could make to this end.

The Queen's Institute of District Nursing had a stand at the Health Exhibition, the focal point of which was a map showing the distribution of the 122 local health authorities (out of a total of 145 in England and Wales) connected with the Institute by membership or affiliation. Aspects of the Institute's training and educational activities were also covered, and the stand was manned by district nurses from Devon and the Torquay home.

HEALTH VISITOR INTEGRATION IN GENERAL PRACTICE

MOST general practicioners know little of the potentialities of a health visitor, and few health visitors know the size of the social component of general practice. Consequently the G.P. and the health visitor pursue their own courses unaware of the mutual problems being tackled separately; the health visitor not being aware of a large amount of social needs, to which she can only be introduced by the G.P., and the G.P. not having had the training necessary to cope with pressing social problems in his practice.

In an attempt to come to grips with this problem, an approach was made by a general practitioner partnership of three doctors in Birmingham to the medical officer of health, suggesting a joint study in which a health visitor would be attached to the practice for a year, and her deployment be controlled by herself and the partnership rather than the council house. This followed a previous limited study in the practice of one of the partners in which it was shown that much could be gained from a study of this nature.

With the ready co-operation of the medical officer of health, the study has now begun. An attempt is being made to estimate the usefulness of the health visitor by the health visitor herself, and by the doctor independently.

Though, as yet, insufficient time has elapsed to draw conclusions from the study, it can be said that those social problems that have arisen have been dealt with more efficiently and followed up more carefully by the health visitor than would have been the case if the G.P. had had to cope with the problems himself. It can also be stated that the health visitor has been directed to problems which would not have come her way, had there not been the referral by the G.P.

There has been an improvement already in the standard of care of socially vulnerable groups such as mothers, babies and the elderly, and the practice list of 8,300 seems to be about the right size to provide enough social problems to ensure the full time employment of a health visitor.

Neither the health visitor nor the G.Ps. are satisfied that the training health visitors receive is the most appropriate, and suggestions as to possible alterations in the course of study may come out of this study.

In conclusion, the general practitioners and the health visitor are enthusiastic about the venture. The preventive and teaching aspect of health education in the practice is being enhanced, and the health visitor is able to make full use of her potential as a social worker trained in nursing and midwifery.

L.A.P.

The importance of parents being informed as fully as possible about the handicap, its causes and treatment, and the future of their child, cannot be stressed too strongly

Helping Spastics and their Parents

by **SHIRLEY KEENE**

National Spastics Society Lecturer

DURING recent years many countries have recognised the great need of the cerebral palsied. Although a number of them are attempting to bring some measure of help to young spastics, few are tackling the problem of adults, for it is felt that there is little hope of improvement at a late stage.

In most of the countries now giving active help to their spastics, the original impetus has come from the parents. England is certainly an example of this, for although there was some treatment available before the National Spastics Society was formed by a group of parents in 1952, immense strides have been made since then. Since its inception, national awareness has been awakened more fully to the problem, and in consequence the facilities available through local authorities now have a far wider scope.

As most surveys indicate that between one and two babies in every thousand born in Britain are cerebral palsied, some idea of the size of the problem may be grasped. The Society estimates that there are about 35,000 spastics in this country, but believes that this may be a low estimate. There are about ten or twelve thousand of school age, and it is possible to get fairly accurate statistics about this group. Figures concerning children below the age of five, adolescents and adults are much more vague.

The vagueness concerning the infant group is still partly due to the fact that it is difficult to diagnose early. Thus, parents may be told that their baby is a "bit backward" or even that the child is mentally defective. There can, of course, be no arbitrary statement concerning the age at which diagnosis can be made, for this depends on the degree of handicap.

Even with a diagnosis, the parents often still lack real explanation of the disability, and due to their own ignorance, keep the child hidden and are unwilling to accept help and advice concerning its welfare. They fear the social stigma that they imagine a brain-damaged child will bring and, not fully realising that this is no reflection on themselves, cannot accept the child's handicap and thus seek the help needed.

The importance of parents being informed as fully as possible about the handicap, its causes* and treatment and the future of their child, cannot be stressed too strongly. A good parent/child relationship, important as it is when a normal child is involved, is doubly important if the child is handicapped; the unanswered fears of the parents must not be allowed to mar it. When parents first hear that their child is spastic (or indeed handicapped in any way) the shock must be accompanied by information and advice to help overcome the difficulty in accepting their child's handicap and to lay the foundations of a satisfactory parent/child relationship.

The National Spastics Society has 120 affiliated parents groups in England and Wales, all bringing self-help in some way to their members. Their function is governed by the amount of help and treatment available from local authorities. Some areas are very well catered for, and the group concentrates on bringing some social life to its spastics. Some groups, however, operate full-scale treatment centres which provide, in addition to physiotherapy and speech therapy, education from specially trained teachers. In either case the parents benefit almost as much as the children, both in rest from the constant care their child requires and from the knowledge that they do not face their problem alone.

The cut-out portions of the special play table help to give support and a feeling of security to children wtih poor balance

These centres are financed by funds raised by the groups and the National Spastics Society pays a grant of 25 per cent of the running costs. In some cases local authorities help, perhaps making available low rent accommodation, paying the fees of a physiotherapist, lending a teacher or providing transport; in other cases parents must raise sufficient funds to meet all costs. It is not possible to generalise about the aid given, for it depends very much on the attitude of the individual authorities toward the cerebral palsied.

Many of the local centres operate as nursery centres, for it is fully realised that the younger the child begins treatment, the more likely it is to benefit. Also, if its handicapped limbs can be kept pliant there is less likelihood of crippling into distorted positions later. In some cases young children who began treatment at eighteen months or two years have improved sufficiently to go on to ordinary schools. This will depend, of course, on the degree of handicap and the child's response to treatment.

These centres provide the children with an opportunity of playing with others and exploring ordinary sensory experience, of which they are often severely deprived. The children are encouraged to handle things and to be as mobile as possible. If a child cannot crawl (let alone walk) but can nevertheless roll over, it is urged to explore the playroom by this method.

Craftwork by young adults at one of the centres *Photograph by courtesy of Croydon Times*

Adaptations

Special equipment is often adapted on the premises; chairs with sloping seats, knee separators and head supports to aid a good sitting position; large handgrips for spoons so that self-feeding may be attempted and similar adaptations for pencils, chalks and paint brushes so that children can experience the joy of self-expression. Individual adaptations are made after advice from the consultant and physiotherapist, and the children's chairs, etc., at home are similarly adapted. Toys must be large enough for the children to grasp in insecure hands, and sturdy. Mothers are advised on lifting, dressing, feeding and toilet methods, and sometimes mothers make up a rota for mealtimes. It is good that they should attend to children other than their own.

Some local centres concentrate on facilities for ineducable children for whom, if they are too severely handicapped to attend an occupation centre (always providing there is one in the area) nothing is provided. Physiotherapy is usually available as well as occupational therapy. The children benefit a great deal, both socially and physically and, just as important, the mothers have a much-needed break. The value of this work is inestimable, for the plight of these families (for the whole family is involved) has been long neglected.

Work centres for adolescents and young adults are another aspect of local activity. In many cases after they have left school, there is nothing for these young people to do but live at home on national assistance—a depressing and frustrating existence. Several work centres are in operation and more are planned. Usually some light machinery and a small printing press are installed as well as the more conventional craft work equipment.

The "workers" are paid a pound a week which does not interfere with their national assistance nor make them liable to pay national insurance contributions. Although many of these spastics would not be able to find a job in open employment, the standard of work produced at the centres is high, and its psychological value immense.

On a national scale, the Society operates eleven centres. There are four residential schools for children aged between five and sixteen years, two offering ordinary education, one for spastics reputed to be below average intelligence and one long-term assessment centre. Further education is offered at a residential secondary modern and grammar school for spastics over eleven years; and there is vocational training at a residential centre, and at the three centres for heavily handicapped adults which cater for age groups between 16 and 25, 16 and 35, and 25 upwards. In addition there are two holiday homes.

Further information concerning these, or any other aspects of the Society's work, and details of local centres operated by affiliated groups, will willingly be provided by the National Spastics Society, 28, Fitzroy Square, London, W.1. The Society will welcome invitations from groups of district nurses interested in hearing a speaker and seeing the Society's film.

* Known causes of cerebral palsy are birth trauma, rhesus factor, association with prematurity and anoxia, and also with jaundice and meningitis shortly after birth. Between 30 and 50 per cent of the cerebral palsied were premature. Medical research can find little indication of hereditary factors.

The Ascertainment and Testing of Deafness in Young Children

by PATRICIA FAWKES, S.R.N., S.C.M., Q.N. and H.V. certs.

TWENTY-FOUR Norfolk County Council health visitors attended a course on the ascertainment and testing of deafness in young children given by Dr. Ian G. Taylor, of the department of Education of the Deaf, Manchester University, in Norwich last autumn.

We learnt not only how the screening tests are carried out, but also about the child as an individual, how each case differs, and how each one should be approached.

These tests, as Dr Taylor pointed out during his introductory talk, are used not to diagnose deafness but to screen for normal hearing. A child passes or fails the test and failure may not be due to deafness. A child may be unwell at the time of testing. Failure necessitates further testing a week later and if deafness is still suspected the child is referred to a deaf clinic for definite diagnosis and assessment.

Wide Effects of Deafness

These tests have become an important part of our work, for proper hearing is vital for the normal development of every child. A child who is deaf becomes not only backward in speech, but experiences an inability to express its feelings and thoughts, and becomes frustrated. Emotions, intelligence and personality are all affected.

The tests are based on early diagnosis. Certain children should be tested routinely: e.g. premature babies, those with abnormal obstetrical histories, congenital abnormalities or cerebral palsy; those who have suffered from rhesus incompatibility, otitis media, meningitis and other infections. There may be a familial tendency to deafness.

Deafness, particularly high frequency deafness, may be overlooked, and a child who is not, at the appropriate age, speaking or responding to sound may be classed as mentally defective. In time, health visitors will endeavour to test each child as it reaches a certain age, namely eight months. Children attending for this course ranged in age from eight months to four years and as the health visitor commences work in her area she will have to test children of the varying ages.

The health visitor is in constant touch with the pre-school child and is, therefore, well able to carry out the screening tests. Screening can be carried out in the home, but obviously numbers will make attendance at welfare centres desirable.

At the first morning session we relaxed and watched Dr Taylor carry out the tests with amazing dexterity. During the afternoon and following morning we were on the job ourselves.

If, as we moved about the Assembly Rooms during breaks, we looked most serious, even glum, it was due to the fact that we felt a little frustrated and humbled: most of us doubting our ability to approach these children of differing ages in order to gain their co-operation.

A hearing-test does not consist merely of making sounds here and there! Each child must be in the right attitude mentally, to be receptive to the sounds made. The sounds themselves are, naturally, important. They must be minimal, at the correct pitch and location, and must be meaningful to the child.

The tests carried out vary according to the age and ability of the child. Children under one year old are tested by distraction with laryngeal sounds, rattles, cup and spoon and breath consonants.

Children of 18 months are tested through co-operation and obey simple commands. Children of three to four years are tested on performance, for they have an understanding of speech.

The arrangements for the course were excellent, and for our benefit and instruction some very attractive children attended with their mothers. The children were carefully selected by local health visitors.

We health visitors worked in pairs, one maintaining the child's attention with toys, and the other making the tests from appropriate positions. Some of us had ideal subjects, but others were not so fortunate.

Different Reactions

One baby became, according to Dr. Taylor, mesmerised by the activity in front of him and really needed stimulating. Another became too excited and had to be calmed down. One little two year old literally took charge of the situation: he trotted to and fro across the room, examined all the toys, but did finally concentrate his attention long enough for the test to be carried out. The health visitors were by this time on bended-knees.

The shy child created an equal problem. It was pointed out that we had been coercing this child instead of expecting co-operation from the start. Our instructor had the little girl handling bricks in no time.

We tested two particularly interesting youngsters. One boy of three years was certainly deaf. He had had meningitis when a few months old. Another baby, a premature one, obviously had faulty hearing though a loud noise behind each ear did cause the eyes to blink. In some cases, failure to pass the test was developmental: a child still needing support when sitting usually finds difficulty in detecting sounds. Another failure to pass was probably due to the child having a cold: detection of low frequency

sounds and location seemed difficult. A child with cerebral palsy was naturally slow in reaction. A mongol child had to be tested according to her ability.

We endeavoured to find time to put into practice what we had learnt and early this year we attended the Assembly House again for our examinations by Dr Taylor. I am glad to say that we all passed and have received our certificates.

Note by County Superintendent Nursing Officer:

It is hoped that all health visitors in the county will soon hold this certificate.

Dr Taylor pointed out that training for these screening tests is usually given in counties and to groups, and very rarely individually. Health departments interested apply to the university, which gives particulars of the numbers which could be dealt with and the types of children required for demonstrations and practice.

Mothers then have to be approached and asked if they would co-operate and bring their children. Bus fares were paid or mothers fetched by the health visitors in our instance.

COMPLACENCY

MORE and more people are becoming seriously ill as a result of being infected in hospital. In one hospital during the first nine months of 1959 there were 250 cases of staphylococcal infection among patients, and one out of every 28 persons admitted acquired a fresh infection or disease after admission.

The causes of this disquieting increase in hospital sepsis are attributed to the many antibiotic-resistant strains of bacteria which have appeared, and too much reliance by hospital staff on drugs and insufficient attention to aseptic principles.

Johnson and Johnson have recently introduced to this country a film made in America *Hospital Sepsis—A Communicable Disease*, which underlines this problem and suggests effective measures of inhibition and control. The film's main purpose is to remind and to state afresh the basic principles involved.

This is something it is well to do in any sphere: the current parallel in the public health field is vaccination and immunisation. So few cases have been reported in this country of recent years that complacency has set in and fewer and fewer mothers are taking advantage of the facilities available to ensure freedom from infection for their children.

It is up to all public health nurses to impress on these mothers the importance of continued prophylaxis against the killing and crippling infectious diseases. Perhaps if each mother can be made to realise that *her* child could easily be crippled by polio, or made to imagine how that same child would struggle to get breath into its lungs while suffering from diphtheria, she may be more ready to suffer the small inconvenience of bringing the child for the vital inoculations.

ANGEL'S TEARS

Diary of a District Nurse—No. 2

"HULLO, Nurse Grey, may I come in?"

"Of course Anthea. Are you off duty again? Seems only last week you were off for the week-end. I was just making a cup of tea; come and sit down."

"I am going on night duty so I have two days off before I start. There's something I want to ask you Nurse Grey: do you ever have a day off or a weekend free?"

"Of course I do. Do you think district nurses are machines that work 24 hours of the day? I have a day off every week and a weekend once in six weeks —and five weeks' holiday a year! Very different from the old days."

"But I thought you were tied to the end of the telephone?"

"Nonsense! We have to have time off otherwise we would become stale and dull. There's nothing worse than a nurse who is so dedicated to her job that she won't go off duty. They are usually awful bores and have no other interest in life, and have no sense of humour. I expect you have met the type in hospital?"

"Yes. The staff nurse in my ward is like that, always the last to go off duty and doesn't think anyone else can do a thing right."

"It's a pity they are such good people because they are so invariably dull."

"Do tell me another story please. You must have many about babies. They usually come at such awkward times, don't they?"

"Yes, they are inconsiderate little things, usually come in the small hours of the night. I remember. . . ."

Anthea settled herself down comfortably as Nurse Grey began.

"One night I was called out about ten o'clock to a young girl who was expecting her first baby. I had visited her several times during her pregnancy and she was a sensible girl for her age. There were no abnormal symptoms and she should have had a perfectly normal labour. But for some reason—no one can understand why these things happen —she had a long and difficult labour. I had to call the doctor in the small hours as nothing was progressing as it should have done, and he had to perform a forceps delivery. The baby was a healthy pink little boy who cried lustily. I stayed until his mother came round from the anaesthetic and was quite comfortable. I returned home in time for my breakfast."

"Did you have to do your normal day's work after being out all night?" Anthea interrupted.

"I only did what was necessary and then had a nap in the afternoon. Well, to continue about Mary and her baby son, everything went perfectly well for the next two weeks that I was visiting her. The baby fed properly and did all that was required of him; perhaps he was too good. Mary was splendid and made an excellent mother and yet I wasn't very happy about him. I left her after two weeks and they were so well that I felt my fears were groundless.

"I had plenty to do on the district in the meantime, and heard from the health visitor that they were both flourishing.

"Now when anything is going to happen on the district it will happen on a Saturday night when there is no surgery and the doctor is out. The telephone rang one April evening and I heard Mary's voice.

" 'Please Nurse, could you come and look at baby. He seems awfully queer tonight and doctor's out.'

" 'How do you mean "queer" Mary?'

" 'He has had two fits today. He hasn't been well since last Wednesday. Doctor saw him and said keep him indoors.'

" 'I'll come right away,' I told her. I didn't like the sound of the fits at all. "

"What did you think was the matter with him?" Anthea asked.

"I didn't know; he was only eight weeks old. However, I went as quickly as I could and was at their cottage by half past six. I was shocked when I saw the baby as I hadn't seen him since he was about a month old. He was lying flat in his pram gasping for breath. His little white face had a bluish tinge round the nose and mouth. The kitchen was like an oven, with a roaring fire and all the windows shut. The country people prefer to keep fresh air outside. I promptly sat him upright and stuffed a couple of pillows behind him.

" 'Nurse, will he be all right? You told me not to give him a pillow' Mary asked pathetically.

" 'Not when he's well, but when they are ill with a chest condition they must be propped up. Now we will do everything possible to help him. You run down to the farm and telephone the doctor's house, leave a message from me that I want him to come here as soon as he comes in. In the meantime, Jim (that was Mary's husband), go to my car and bring me the oxygen and a spare cylinder.'

"As soon as they had something to do they were splendid, and in a very short time we had the oxygen fixed up and the little fellow was breathing more easily. I only hoped the oxygen would last until the doctor came. I asked Mary to make us some tea which we were drinking, sitting round the baby's pram, when the doctor arrived. He saw how ill the baby looked as he walked in.

" 'Whew, how long has he been as ill as this, Mary?'

" 'Since this morning, he had a kind of fit.'

" 'Has he had any more?' he asked as he pulled his stethoscope from his pocket.

" 'Yes, one about tea time, when I became worried and called nurse.'

RETIREMENT PRESENATIONS IN FIFE

GIFTS from colleagues and from local communities have marked the recent retirement after many years of valuable service, of three Queen's nursing sisters in Fife.

Mrs. M. Connochie received a cheque from public subscribers a few years ago when she completed 25 years in Anstruther. Now retiring after a total of 33 years, Mrs. Connochie has received a gift from the medical and nursing staff.

Miss Margaret Livingstone spent 32 of her 38 years in Buckhaven. At a farewell party her colleagues presented to her a tea trolley and china tea set.

Miss Flora Walker has been a district nurse for 29 years, 21 of them in Pittenweem and Carnbee. She received a travelling clock and a cheque for over £100 from a public subscription. The medical and nursing staff contributed a wallet of notes. Local school children added their gift at a special ceremony, and the former district nursing association also presented a cheque.

"He looked grave and listened to the baby's heart and lungs for a few minutes.

" 'I am afraid he is very ill, Mary, we will have to get him into hospital as soon as possible.'

" 'What is it, doctor? He will get better, won't he?' The tears were coursing down poor Mary's face.

"The doctor put his arm round her shoulders and made her sit down.

" 'Now Mary, we want him to get better. That is why we are sending him into hospital. You will have to go with him as you are feeding him, so you won't be separated. One of his lungs isn't working properly, that is why his breathing is so difficult. Now you pour me a cup of tea while I 'phone the hospital and the ambulance.'

"It was eleven o'clock before the ambulance arrived; it had to come ten miles from the nearest town and through some very narrow lanes and farm tracks. Mrs. Crest, the driver, was an amazing woman. She drove the ambulance herself and coped with all emergencies. Very soon she had the oxygen flowing evenly in the ambulance and the baby's carry-cot with the baby cosily surrounded with hot water bottles on the stretcher. Mary and I sat opposite him all the way watching his every breath. It was close on midnight when we reached the hospital and I wasn't sorry to hand him over to the waiting night sister."

"Did he live?" Anthea asked.

"Yes, for a few months. Mary went with him from one hospital to another and eventually he was sent home."

"What was the matter with him really?"

"Mary never knew that his left lung hadn't developed properly. It was all right at birth and until he was eight weeks old, but as soon as he caught a cold he couldn't cope with only one lung. She said the doctors were going to operate when he was a year old."

"Did you see him again?"

"Yes, once when he came home I went up to the farm to see him. Mary was busy in the house and didn't hear me arrive so I walked over the grass and looked into the pram. I felt my eyes smart as I looked at him—he looked so tiny, as small as a three-month old baby and yet I knew he was eight months old."

" 'Isn't he lovely, nurse? He weighs twelve pounds now.' (As he weighed eight pounds at birth it wasn't much) I hadn't heard Mary come across the grass behind me.

" 'Yes, he has grown since I last saw him.' I agreed as I looked at the pathetic little fellow. I knew he wasn't long for this world."

"How long did he live?" Anthea asked.

"Only another month. He had a peculiar attack and was rushed back to hospital but he died before anything could be done. It was a blessing really because he would never have been normal."

Nurse Grey glanced down at the young girl curled up on the rug and saw her eyes were wet.

"My dear, you musn't let my tales upset you."

"It was so sad for his young mother," she sniffed. "She was only my age."

"Well, I hope nothing sad like that will happen to you. As nurses we see so many tragedies and heartaches that we have to keep our feelings to ourselves, otherwise we could never do our work satisfactorily. You would get too upset if you didn't learn to control your emotions and that would never do. Come and tell me how you like night duty next time you are free, and I will tell you something amusing that happened to me one night on my district."

C. A. Russell, S.R.N., S.C.M., Q.N. cert.

MINI-MINORS FOR BERKSHIRE NURSES

Photograph by courtesy of Reading Mercury

Eight of the twenty-one district nurses employed by Berkshire County Council with the new Mini-Minors which they recently exchanged for their ten-year-old cars

correspondence

Uniform Changes

AS present events are now shaping the outline of things to come, I would suggest that some change is necessary in the uniform of the domiciliary services. I feel strongly that this should be looked into immediately and future plans formed or else some change may be forced upon us. This calls for clear unsentimental thinking and planning which will take into account our allegiance to the Queen's Institute and yet bring us up to date with modern developments. May I put forward the following suggestions:

1. Retain navy blue uniform and delphinium blue dresses for all district nurses, white blouses for administrators.

2. Do away with epaulettes and Q.I.D.N.S. marking, also present Queen's badges.

3. Where Queen's trained: I suggest for a nurse a bronze replica of present badge which could be worn in hat or as a brooch on coat; administrators—a small silver replica or badge to be worn as brooch either on hat, blouse, or coat lapel (do away with large or small badges). These brooches I feel should be bought by the individual person from the Q.I.D.N. As a county nursing officer it has for a very long time seemed desirable to me to wear no outstanding markings of rank or particular qualification as it is important to be acceptable to all members of one's staff whatever their qualifications. The flashes, etc. are a very expensive item.

It should like to see this dealt with as a matter of urgency and the changes agreed and adopted by the end of this year at the latest.

J. E. Nobes,
County Nursing Officer, Somerset.

Gardens Film

The film *The Gardens of Britain*, made for The National Gardens Scheme by Fisons Limited, is proving extremely popular, and bookings are already being made for 1962; at the time of going to press the film is fully booked up to May 1961. Enquiries should be sent to Sound Services Film Library, Wilton Crescent, London, S.W.19. The charge for hiring this 40-minute film in colour with sound commentary has been increased from one guinea to thirty shillings, as it is evident that the demand for the film is going to continue long enough to make replacement of the present copies of the film essential.

Queen's Nurses Personnel Changes

APPOINTMENTS
Superintendents, etc.

Guttman, C. J., Dep. Area N.O., Dorset—Keenan, M., Sec. Asst., Metropolitan D.N.A.

Nurses

Adams, S. J., Dorset—Angell, J. V., Portsmouth—Bennett, P. B., Manchester (Harpurhey)—Cockrill, D. R., Oxon.—Curnow, J. E., Worcs.—Dunkley, M., E. Sussex—Edwards, E. R., Som.—Haden, Mr. R., Coventry—Kevitt, G., Devon—Quinn, G., Devon—Robinson, J., W. Riding—Smith, O., Som.—Sutcliffe, E., W. Riding—Topley, D., W. Riding—Vine, Mr. V., West Ham.

LEAVE OF ABSENCE

Chambers, H., H.V.—Painter, Mrs. N., personal—Ross, F. L., personal.

REJOINERS

Angell, Mrs. J. V., Portsmouth—Bennett, Mrs. P. B., Manchester (Harpurhey)—Boote, Mrs. A. H., Cheltenham—Brannigan, M. J., Cheshire—Cox, Mrs. J., W. Riding—Day, Mrs. K., Dewsbury—Drake, E. E., Exeter—Evans, E., W. Riding—Hopson, Mrs. G. M., Herts.—King, Mrs. J. W., Lady Rayleigh Trg. Home—Kirwan, Mrs. D. M., Manchester (Harpurhey)—Kissack, Mrs. P. M., Nottingham—McHugh, S. M., Manchester (Harpurhey)—Marlow, Mrs. M., Coventry—Perkins, Mrs. O., Plymouth—Perry, Mrs. F., Warcs.—Sherwin, Mrs. S., Gateshead—Tomlinson, Mrs. P. R., Leics.—West, Mrs. E., Portsmouth.

RESIGNATIONS

Baron, Mr. K. A., Worcester, personal—Beaton, B. M., Kensington, S.S.A.F.A.—Brown, V. E., Wigan, personal—Brunt, A., Devon, abroad—Burdg, N. J., Som., work in Canada—Damole, N. R., Middx: Area 6, return to Nigeria—Davey, L. M., Devon, personal—Dunn, M. D., Plymouth, abroad—Dunne, K., Liverpool, personal—Fraser, E., Liverpool, personal—Greenwood, M. H., Chester, abroad—Griffiths, S. E., Merioneth, retirement—Hand, M. E., Flints., personal—Jary, O. M., Essex, personal—Jones, D., Huddersfield, marriage—Jones, K. M., Merioneth, H.V. post—Peters, G. G., Devon, marriage—Pidgeon, M. H., Som., personal—Prentice, R. E., Devon, retirement—Price, G. M. N., Swansea, marriage—Rankin, O. P., Plymouth, abroad—Raw, E. J., Portsmouth, retirement—Rawlings, J. W., Som., personal—Richards, P. M., Middx: Area 6, personal—Shipp, H., E. London, personal—Solonyna, Mrs. B., Nottingham, personal—Walch, E., W. Riding, personal—Welsh, M. B., Belfast, marriage—White, E. J., Belfast, work in Canada—Whiteside, J., Rochdale, personal—Williams, A. M., Swansea, personal—Wilshire, M., Warrington, personal.

SCOTTISH BRANCH

APPOINTMENTS
Nurses

Boyd, A. G. B., Windygates—Brown, J. A. T., Musselburgh—Campbell, Mrs. S. G., Newton Stewart—McConnochie, E., Buckie—Mackay, D. J., Watten—Morrison, A. B., Inverness—Playfair, C. R., Buckhaven—Ramage, J. L., Penpont—Thomson, E., Elgin.

REJOINERS

Mackenzie, M. F., Ross-shire C.R.N.—MacKinnon, C., Kilmarnock—Malley, A., Sauchie—O'Kane, A. L., Carradale

RESIGNATIONS

Copland, Mrs. C. F., Forres, other work—Duncan, D., Balfron, marriage—Harkness, Mrs. M., Penpont, retired—Lennon, A., Stenhousemuir, work abroad—Toland, A., late of Clydebank, health reasons—Walker, F. R., Pittenweem, retired.

FLOWERS FROM THE CHILDREN

Photograph by courtesy of The Stroud News & Journal

Susan Kirby presenting the children's tribute to Miss Evelyn Sharpe when she retired after twenty years as district nurse at Rodborough, Gloucestershire

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Displayed Setting: 17s. 6d. per single column inch: £2 per double column inch. Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.). Ruled border 5s. extra

WARWICKSHIRE COUNTY COUNCIL

Applications are invited from the undermentioned vacancies. Where house or other accommodation available, this can be either furnished or unfurnished. Consideration will be given to the granting of financial assistance towards removal expenses, and for driving tuition. Motorists can receive allowance for own car or car will be provided.

District Nurses, District Midwives, District Nurse Midwives

Area 1—**Sutton Coldfield** (town)—district midwife—motorist—house.

Area 2—**Atherstone, Polesworth, Dordon** and **District** (urban and rural)—two district nurse midwives or one district nurse and one midwife—motorists—flat suitable for friends to share or separate flats ready June.

Bedworth (urban)—district midwives—motorists—part house.

Bulkington (urban and rural)—district nurse midwife—motorist—house—easy access to Coventry, Nuneaton and Leicester.

Area 4—**Coleshill** (urban)—district nurse midwife—motorist—modern flat.

Castle Bromwich (urban)—district midwife—motorist—modern flat.

District Nurse Midwives/Health Visitors

Area 3—**Birdingbury** (rural) two required—motorists—adjoining modern flats or share one.

Area 4—**Berkswell** (rural)—one required—motorist—part house.

Area 6—**Fenny Compton** (rural)—one required—motorist—part house.

Health Visitors

Area 2—**Bedworth** (urban)—two required—motorists—part house.

Nuneaton (town)—two required—motorists—accommodation.

Application forms and full particulars may be obtained from the Area Medical Officer as follows: Area 1—Health Dept., Council House, Sutton Coldfield; Area 2—Health Dept., Council House, Nuneaton; Area 3—Health Dept., Albert House, Albert Street, Rugby; Area 4—Health Dept., Park Road, Coleshill, Birmingham; Area 6—Health Dept., 38 Holly Walk, Leamington Spa.

The Council is a member of the Queen's Institute of District Nursing.

Shire Hall, Warwick. L. EDGAR STEPHENS, Clerk of the Council

KINGSTON UPON HULL CORPORATION HEALTH DEPARTMENT

District Nurses (female) required. Applicants should be State Registered. Salary and conditions of service according to N.M.C. agreements. Forms of application etc. may be obtained from the Medical Officer of Health, Guildhall, Kingston upon Hull, to whom completed forms should be returned as soon as possible.

MIDDLESEX COUNTY COUNCIL

Reqd. in Area 4 (Finchley and Hendon).

1. **Domiciliary Midwife**—Must be S.C.M. and pref. S.R.N. Furnished accommodation available. Applicants should be able to drive a car. Car allowance.

2. **Home Nurse/Midwife**—Must be S.C.M. and S.R.N. pref. District Trained. Will be reqd. to reside in small, attractive Midwives' Home for which an assessed charge for board and lodging will be made.

Both posts: Wholetime. Established, prescribed conditions. N.M.C. Salary, plus London Weighting, if applicable. Provision for uniform. Particulars and two referees to Area Medical Officer, Town Hall, Hendon, N.W.4 by 20th June. (Quote C.441DNJ).

COUNTY OF RADNOR

Country Lovers find congenial occupation as District Nurses in beautiful unspoilt Radnorshire on the River Wye.

Applications are invited for **District Nurse Midwives** at Knighton and at Rhayader where house available. Driving essential. Car supplied or allowance for own car.

Apply: Miss E. J. Bell-Currie, Superintendent Nursing Officer, County Hall, Llandrindod Wells.

WESTMORLAND COUNTY COUNCIL NURSING SERVICES

Kirkby Stephen. Two nurses required to undertake combined duties of Home Nursing, Midwifery and Health Visiting in this small market town and a surrounding rural area in North Westmorland. Suitable for friends. House and cars provided. Applications should be made to County Medical Officer, County Hall, Kendal.

DOUGLAS—ISLE OF MAN

District Nurse/Midwife required for Douglas area. Car driver, accommodation provided if required, no midwifery at present. Low rate of income tax.

Apply: Superintendent Nursing Officer, 3 Harris Terrace, Douglas, Isle of Man.

COUNTY OF RADNOR

Appointment of Health Visitor

Applications are invited for the above appointment from nurses holding the Health Visitors Certificate. This is a new appointment—due to re-organisation.

Salary in accordance with approved scales.

Apply: Miss E. J. Bell-Currie, Superintendent Nursing Officer, County Hall, Llandrindod Wells.

READING QUEEN'S DISTRICT NURSES

Two **Training Midwives** required. Part II Training School. Cars provided or allowance for own cars. Apply: Superintendent, 25, Erleigh Road, Reading.

HEREFORDSHIRE COUNTY COUNCIL

Training Scholarships

Scholarships are offered at recognised training centres for:—

Combined Health Visitor/District Training—for S.R.N., S.C.M. Generalised duties, home nursing, midwifery and health visiting to follow. Grant during Health Visitor's training of 75% of minimum of Health Visitor's salary scale plus tuition and examination fees. Candidates required to serve in the County for two years on completion of training.

District Training—for S.R.N., S.C.M. Combined home nursing/midwifery duties to follow for twelve months on completion of training.

Appointments

Applications are invited for the following appointments:—

Assistant Superintendent Nursing Officer. Candidates must be Queen's Nurse/Midwives with experience complying with regulations for supervision of midwives and holding the Health Visitor's Certificate. Salary scale £685 × £25—£860. Conditions of service in accordance with the Whitley Council recommendatilns.

District Nurse Midwife/Health Visitor (preferably with Queen's and H.V. Certificate or willing to train).

Brimfield—Salop border. House, furnished or unfurnished.

Holmer I—outskirts Hereford. One-bedroomed flat, furnished or unfurnished.

Holmer II—between Hereford and Leominster. One-bedroomed flat, furnished or unfurnished.

Ocle Pichard—between Hereford and Bromyard. Double district—would suit two friends; normally off duty together. New detached house, furnished or unfurnished.

Candidates for these appointments should be motorists—car provided or allowance for own car.

Application forms and terms of scholarships and appointments may be obtained from the County Medical Officer, 35 Bridge Street, Hereford.

READING QUEEN'S DISTRICT NURSES

Assistant Superintendent required to be in charge of small Home. Midwifery experience essential. Post provides excellent experience in administration. Apply: Superintendent, 25 Erleigh Road, Reading.

GLOUCESTER DISTRICT NURSING SOCIETY

Queen's Training Home

Applications are invited for the post of **Assistant Superintendent** to undertake the supervision of the Home Nursing Department, and assist in the training of Student District Nurses. Full details may be obtained from Superintendent, 14 Clarence Street, Gloucester.

Other Advertisements on p. 72

QUEEN'S INSTITUTE OF DISTRICT NURSING

William Rathbone Staff College

Course in Community Health Administration

Applications are invited from General State Registered Nurses who are (a) district nurses, midwives or health visitors with at least three years' experience in the field; or (b) hospital sisters with at least three years' post-certificate experience who wish to gain a wider knowledge of public health nursing, for the Course in Community Health Administration beginning on 15th September 1960.

Further information and details of available scholarships may be obtained from The Principal, William Rathbone Staff College, 1 Princes Road, Liverpool 8.

QUEEN'S NURSES BENEVOLENT FUND

The Annual Meeting and Bring and Buy Sale will be held on Friday, June 17th 1960 at 3 p.m. at Westminster and Chelsea District Nursing Association, 73, Cadogan Gardens, Chelsea, London, S.W.3.

Gifts in money or kind will gladly be received by Miss M. B. Dixon, superintendent of the home, for the bring and buy sale. Subscribers and friends are asked to give their support to this effort.

Your route: Underground or bus to Sloane Square. Cadogan Gardens is situated behind Peter Jones Store.

QUEEN'S INSTITUTE OF DISTRICT NURSING

Health Visitor Courses, 1960–1961

1. Health Visitor Course

Nine months course approved by the Minister of Health to prepare students for the Health Visitors' Examination of the Royal Society of Health.

2. Health Visitor/District Nurse Course

One year's course to prepare students for:

(a) Health Visitors' Examination; and

(b) Queen's Roll Examination in District Nursing.

District Nurse training may be taken either before or after the Health Visitor Course. The Health Visitor Training is held at the Bolton and Brighton Training Centres and courses begin in September, 1960. The District Nurse training is taken at an approved centre.

Further information and details of available bursaries are obtainable from The Education Department, Queen's Institute of District Nursing, 57, Lower Belgrave Street, London, S.W.1.

CITY OF OXFORD DISTRICT NURSING SERVICE

Queen's Training Home

Vacancies for S.R.N.s who are Midwives or Health Visitors for three month District Training. Courses commencing 2nd week in October 1960 and 4th week in January 1961.

Applications to Superintendent, 39–41 Banbury Road, Oxford.

WARWICKSHIRE COUNTY COUNCIL

Health Visitor Training

Applications are invited from State Registered Nurses holding Part I of the C.M.B. Certificate, to take health visiting training. Training grant of 75% of the minimum salary for a qualified health visitor paid from the commencement of training to the final examination. Interview expenses, tuition fees and examination fees paid, and certain items of uniform provided. Salary on health visitors scale on passing examination.

District Nursing Training

Training arranged and all expenses paid. If combined with health visiting training, grant in addition.

Application forms and full particulars may be obtained from the County Medical Officer of Health, Shire Hall, Warwick.

Shire Hall, Warwick — L. EDGAR STEPHENS, Clerk of the Council

SOUTHAMPTON COUNTY BOROUGH COUNCIL

Training of Health Visitors

Applications are invited from State Registered Nurses, with at least Part I C.M.B. Certificate, for grant-aided Course at Southampton University, commencing September, 1960.

Forms and particulars from Medical Officer of Health, Civic Centre, Southampton.

District Nursin